RELIANCE
General Insurance

reliancegeneral.co.in
1800 3009

PRE-AUTHORIZATION REQUEST FORM

Part 1 Insured Detai

Insured Name: Claim No
Mobile No.: Policy No.:
E-mail Id
If Group Policy, Company Name: Employee id

Part 2 Patient Details

Patient Name:
Patient UHID Age: yrs DOB: dd/mm/yy Gender: ☐ Male ☐ Female
Patient Mobile No: Patient Email id:
Relation with insured: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others
Address:
City; Pin Code
Attendant Name:
Attendant Mobile no.: Attendant email id

Part 3 Service Provide Details

Hospital Name: Hospital Code:
Hospital Address:
City: Pin Code

Contact Details (Hospital Employee)	Treating Doctor's Details
Name:	Name: Dr.
Telephone no./Mobile no	Qualification:
Fax No.:	Registration No.:
E-mail Id	Mobile No.:

Part 4 Case Information (filled by treating doctor)

Presenting Complaint
Duration Date of first onset/Consult
H/O of past illness related to present complaint
Relevant Clinical findings
Investigation findings

Provisional Diagnosis

Treatment Plan: ☐ Medical ☐ Surgical

In case of Maternity
Obstetric History G____ P____ L____ A____
LMP_____ EDD._____

In case to Injury/RTA/Self Injury
Under Influence of Alcohol/Drug abuse ☐ Yes ☐ No
Attached Copy of ☐ MLC ☐ FIR ☐ PI
MLC/FIR Number: Place:

Past Medical History			Duration/Details
HTN	☐ Y	☐ N	
IHD/CAD	☐ Y	☐ N	
Diabetes	☐ Y	☐ N	
Asthma/COPD/TB	☐ Y	☐ N	
Paralysis/CVA/Epilepsy	☐ Y	☐ N	
Arthritis	☐ Y	☐ N	
Cancer/Tumor/Cyst	☐ Y	☐ N	
STD/HIV	☐ Y	☐ N	
Alcohol/Drug abuse	☐ Y	☐ N	
Psychiatric condition	☐ Y	☐ N	
Others	☐ Y	☐ N	

Part 5 Billing details (filled by hospital)

Room Type: ☐ Single AC ☐ Single NON AC ☐ Twin Sharing AC
☐ Twin Sharing NON AC ☐ Multi-bed ☐ Others
Hospital Room Name.:
Type of Admission: ☐ Planned ☐ Emergency
Expected DOA: dd/mm/yy Length of Stay: Days
Package Rate: ☐ Yes ☐ No
If Yes, Package Charges
Implant Charges
Remarks (if Any)

If Package not applicable,

Room Rent + Nursing Charges	
Surgeon/Assistant Surgeon Charges	
Anesthesia/Anesthetist Charges	
Operation theatre Charges	
Doctor's Visit Charges	
Investigation Charges	
Pharmacy Charges	
Implant Cost(if any)	
Total Cost of Hospitalization	

Consent by the Patient/Insured/Beneficiary: I/We understand that Cashless facility is not automatically guaranteed by RGICL. I/We have no objection to RGICL RCare Health Officials visiting the Hospital/Nursing Home to check the details of treatment and are authorized to collect documents pertaining to my treatment from the Hospital/Nursing Home. I/We have provided the necessary information accurately to the best of my /our knowledge. I/We agree to pay the cost of the hospitalization, if authorization given by RGICL RCare Health becomes null and void, due to wrong and incorrect information.

Patient Signature: Treating Doctor's Signature:

Date & Place: d d m m y y y y Stamp of Hospital:

R Care Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.
Reliance General Insurance Company Limited.
Registered Office: 19, Reliance Centre, Walchand Hirachand Marg, Ballard Estate, Mumbai 400001.
Corporate Office: 570, Rectifier House, Naigaum Cross Road, Next to Royal Industrial Estate, Wadala (W), Mumbai 400031.
Corporate Identity Number U66603MH2000PLC128300.

An ISO 9001:2008
Certified Company

RGI/MCOM/MI-14/PRE-AUTHORIZATION REQUEST FORM /VER. 1.2/070415

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IMPORTANT INFORMATION FOR HOSPITALS:

(THIS PAGE IS NOT TO BE FAXED TO RCARE-HEALTH)

1. The member &/or the relative must notify the claim by calling RGICL call centre on Toll Free Voice : 1800-103-1999 for “Claims Intimation”.

2. The call centre would take basic information about hospitalisation and upon successful registration generate a unique “Claim No.” which would be informed to the Insured/member/beneficiary immediately followed by a confirmatory SMS sent to the registered mobile number of the Insured.

3. The Pre-authorisation Request Form should be filled with due care including the unique number received by the Insured/member/beneficiary. All columns are required to be completed in block letters.

4. Completed Pre-authorization Request Form should be faxed to “RCare-Health on 1800-3010-3001 (toll free), 022-39197849 (charges apply)” or emailed at rgicl.rcarehealth@relianceada.com by the provider hospital. It should reach us at least 4 days prior to likely date of admission. In case of emergency admission Pre-Authorisation Request Form should be sent within 4 hours of admission.

5. Authorisation may be denied if complete information is not provided or queries are not replied to.

6. Discrepancy in the information provided by the hospital records found at the time of claim may render the authorisation given null and void and the amount claimed by the hospital would have to be settled by the Insured to the hospital.

7. Any changes in Diagnosis/Treatment plan should be intimated before discharge of the patient.

8. All queries raised by us need to be replied at the earliest & maximum within 24hrs.

9. Request for authorisation/enhancement will not be entertained after discharges of the patient.

10. We promise to fax the authorisation denial letter to the concerned hospital within 24 hours of complete and correct information being provided.

11. If clinical details provided are insufficient, there may be a delay in the authorisation or denial for cashless access.

RGI/MCOM/MI-14/PRE-AUTHORIZATION REQUEST FORM /VER. 1.2/070415

Email: rgicl.rcarehealth@relianceada.com